

## EDITORIALS

## References

- Gauderer MW, Ponsky JL, Izant RJ Jr. Gastrostomy without laparotomy: a percutaneous endoscopic technique. *J Pediatr Surg* 1980;15: 872–875.
- Gauderer MW. Percutaneous endoscopic gastrostomy and the evolution of contemporary long-term enteral access. *Clin Nutr* 2002; 21:103–110.
- Mitchell SL, Teno JM, Kiely DK, Shaffer ML, Jones RN, Prigerson HG, et al. The clinical course of advanced dementia. *N Engl J Med* 2009; 361:1529–1538.
- Grant MD, Rudberg MA, Brody JA. Gastrostomy placement and mortality among hospitalized Medicare beneficiaries. *JAMA* 1998; 279:1973–1976.
- Mendiratta P, Tilford JM, Proshan P, Curseen K, Azhar G, Wei JY. Trends in percutaneous endoscopic gastrostomy placement in the elderly from 1993 to 2003. *Am J Alzheimers Dis Other Demen* 2012;27:609–613.
- Mitchell SL, Mor V, Gozalo PL, Servadio JL, Teno JM. Tube feeding in US nursing home residents with advanced dementia, 2000–2014. *JAMA* 2016;316:769–770.
- Ahronheim JC, Mulvihill M, Sieger C, Park P, Fries BE. State practice variations in the use of tube feeding for nursing home residents with severe cognitive impairment. *J Am Geriatr Soc* 2001; 49:148–152.
- Teno JM, Gozalo P, Mitchell SL, Kuo S, Fulton AT, Mor V. Feeding tubes and the prevention or healing of pressure ulcers. *Arch Intern Med* 2012;172:697–701.
- Gieniusz M, Sinvani L, Kozikowski A, Patel V, Nouryan C, Williams MS, et al. Percutaneous feeding tubes in individuals with advanced dementia: are physicians “choosing wisely”? *J Am Geriatr Soc* 2018; 66:64–69.
- Law AC, Stevens JP, Walkey AJ. Gastrostomy tube use in the critically ill, 1994–2014. *Ann Am Thorac Soc* 2019;16:724–730.
- Mehta AB, Syeda SN, Bajpayee L, Cooke CR, Walkey AJ, Wiener RS. Trends in tracheostomy for mechanically ventilated patients in the United States, 1993–2012. *Am J Respir Crit Care Med* 2015;192:446–454.
- Hope AA, Gong MN, Guerra C, Wunsch H. Frailty before critical illness and mortality for elderly medicare beneficiaries. *J Am Geriatr Soc* 2015;63:1121–1128.
- Mitchell SL, Palmer JA, Volandes AE, Hanson LC, Habtemariam D, Shaffer ML. Level of care preferences among nursing home residents with advanced dementia. *J Pain Symptom Manage* 2017;54:340–345.
- Wilson ME, Hopkins RO, Brown SM. Long-term functional outcome data should not in general be used to guide end-of-life decision-making in the ICU. *Crit Care Med* 2019;47:264–267.
- Halpern SD. Using default options and other nudges to improve critical care. *Crit Care Med* 2018;46:460–464.

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## The Importance of Showing Our Work: Process Transparency in Dispute Resolution

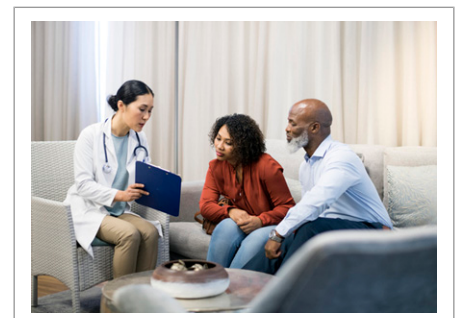
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An Ovid search for use of the term “medical futility” since 1980 returns 7,467 results. Although this subject has received much academic attention, there remain significant gaps in our knowledge about how best to resolve conflicts with surrogates requesting treatments that clinicians believe should not be provided. Most of the existing literature can be assigned to one of three clinician-centric categories: 1) descriptions of common surrogate requests and theoretical resolution strategies, 2) communication interventions to prevent disputes, and 3) explorations of how requests for a potentially inappropriate treatment make clinicians feel. There have been comparatively few investigations into how surrogates experience these disputes outside of the contentious situations where conflicts

rise to the level of public discourse, as in the cases of Charlie Gard and Jahi McMath (1, 2).

In 2015, a policy statement approved by multiple critical care societies, including the American Thoracic Society, proposed using the broader term “potentially inappropriate” to encompass all situations in which clinicians believe competing ethical considerations justify withholding treatments (3). This statement outlined a multistep process for responding to surrogates’ requests for such interventions in intensive care units (ICUs). In this issue of *AnnalsATS*, Bailoor and colleagues (pp. 738–743) explore the reactions of uninvolved lay citizens to clinical vignettes concerning resolution of requests for potentially inappropriate treatment via this process (4). A nationwide sample of 1,191 adults reviewed two vignettes in which clinicians withheld one of two treatments



against the wishes of the patient’s daughter: chemotherapy in the setting of metastatic cancer and hemodialysis after a devastating intracerebral hemorrhage. Half of the respondents were randomized to receive “process information.” These respondents were told that the team obtained a second opinion from an independent physician, had the case reviewed by the hospital ethics committee, and explored whether the

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patient could be transferred to another institution. The other half of the respondents did not receive this process information. The primary outcome was a four-point Likert scale assessing responses to the question, “How appropriate do you find the decisions made by the doctors?”

Two of the study’s findings are noteworthy. First, acceptance of the decision to withhold treatment was high. Combining both vignettes and treatment arms, more than 77% of the respondents rated withholding treatment as appropriate. This demonstrates that a majority of uninvolved Americans support decisions to withhold therapies when clinicians believe that treatment would be of no benefit or that the risks and harms outweigh the benefits. This finding is consistent with a 2009 study in which 82% of *actual* ICU surrogates agreed to withhold treatment in a hypothetical scenario (i.e., not their loved one’s scenario) when clinicians believed the patient had no chance of survival (5). Some data support the intuitive finding that surrogates’ agreement with an initial recommendation of withholding or withdrawing treatment is lower when the subject is an *actual* loved one. In a study in a pediatric ICU, when clinicians approached families regarding withholding or withdrawing life-sustaining treatment, 51% of families agreed in the first family meeting with the assessment (6). This agreement went up with each additional family meeting (reaching >98% agreement after multiple meetings).

The second novel finding is the effect of process transparency on public acceptance of the decision to withhold treatment.

Acceptance was improved by approximately 10% in both scenarios when the resolution process used by the treating team was discussed with transparency. This simple intervention had a number needed to treat of 10 to prevent one disagreement—a success rate better than most standard pharmacologic interventions (for example, the number needed to treat to prevent ischemic stroke with anticoagulation is 25) (7).

Interestingly, the respondents were asked to address the vignettes not from the point of view of the surrogate, but as an uninvolved observer. There are at least two possible views of how this aspect of the study design impacts interpretation of these findings. A purist evaluation would lead to the conclusion that this study addresses the general public’s views of these situations. However, because it was evaluated from a third-party perspective, it is difficult to conclude whether such transparency would have the same effect in bedside disputes that don’t rise to the level of a national discussion.

A more interpretive assessment would view this study as a thought experiment that removes emotion and personal context from the respondent. In this view, participants’ responses represent the views of surrogates at the bedside from a dispassionate standpoint. Thus, process transparency appears to be an effective means of improving surrogates’ acceptance of disputed recommendations, and should be a standard part of the resolution process.

The authors acknowledge that studying a group of third-party individuals is far

removed from trialing interventions with actual surrogates. But this study seems to add empiric support for process transparency at the bedside, a step that 1) is consistent with current guidelines in the aforementioned American Thoracic Society policy statement, 2) is likely to be of low risk and beneficial to surrogates, and 3) is without added cost, assuming that a guideline-based resolution process occurs regularly.

Perhaps the most surprising aspect of this study is the fact that the authors felt compelled to carry it out in the first place. (And this is not a refutation of its value—we found this study compelling and informative.) That we feel the need to empirically justify open communication about a systematic medical decision-making process speaks volumes about the current state of patient–physician communication in the United States. Clinicians in the United States remain responsible for directing difficult decisions at the extremes of life at a time when ideas about previously unassailable concepts, such as the definition of death, are evolving (8). The steps outlined in the multisociety policy statement are meant to ensure that we will do what we believe is right while also having the humility to check with colleagues about our assumptions. This study establishes that one of the fundamental ways of improving communication and building trust in contentious situations is simply to show our work. ■

**Author disclosures** are available with the text of this article at [www.atsjournals.org](http://www.atsjournals.org).

## References

- Hurley R. How a fight for Charlie Gard became a fight against the state. *BMJ* 2017;358:j3675.
- Luce JM. The uncommon case of Jahi McMath. *Chest* 2015;147:1144–1151.
- Bosslet GT, Pope TM, Rubenfeld GD, Lo B, Truog RD, Rushton CH, *et al.*; American Thoracic Society ad hoc Committee on Futile and Potentially Inappropriate Treatment; American Thoracic Society; American Association for Critical Care Nurses; American College of Chest Physicians; European Society for Intensive Care Medicine; Society of Critical Care. An official ATS/AACN/ACCP/ESICM/SCCM policy statement: responding to requests for potentially inappropriate treatments in intensive care units. *Am J Respir Crit Care Med* 2015;191:1318–1330.
- Bailoor K, Valley TS, Kukora S, Zahuranec DB. Explaining the process of determining futility increases lay public acceptance. *Ann Am Thorac Soc* 2019;16:738–743.
- Zier LS, Burack JH, Micco G, Chipman AK, Frank JA, White DB. Surrogate decision makers’ responses to physicians’ predictions of medical futility. *Chest* 2009;136:110–117.
- Garros D, Rosychuk RJ, Cox PN. Circumstances surrounding end of life in a pediatric intensive care unit. *Pediatrics* 2003;112:e371.
- Aguilar MI, Hart R. Oral anticoagulants for preventing stroke in patients with non-valvular atrial fibrillation and no previous history of stroke or transient ischemic attacks. *Cochrane Database Syst Rev* 2005;(3):CD001927.
- Pope T. Brain death and the law: hard cases and legal challenges. *Hastings Cent Rep* 2018;48:S46–S48.

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